

PPO Copay 90/70 Benefit Summary

\$0 Deductible



City of Surprise Group #23348 Effective 07/01/2012

Federal and state statutes and regulations may require additional changes to this benefit plan. BCBSAZ will advise employer groups and members of any additional changes to this benefit plan required by applicable federal and state law.

	COST SHARE									
	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER								
Plan-Year Deductibles	<p>\$0 per member, \$0 per family</p> <p>Applicable deductible must be met for all covered services unless otherwise stated.</p> <p>Copays, access fees, precertification charges and noncontracted providers' balance bills do not count toward the deductible.</p>	<p>\$300 per member, \$600 per family</p>								
Coinsurance This is a percentage members must pay for certain covered services after meeting the plan-year deductible.	Plan pays 90%, member pays 10% (90%/10%) of the allowed amount for most covered services, after meeting deductible, unless a copay or different coinsurance percentage is indicated.	Plan pays 70%, member pays 30% (70%/30%) of the allowed amount for most covered services, after meeting deductible, unless a copay or different coinsurance percentage is indicated.								
Plan-Year Out-of-Pocket Coinsurance Maximums	\$1,500 per member, \$3,000 family.	\$3,000 per member, \$6,000 family.								
How we calculate coinsurance and accumulations toward plan year deductibles and out-of-pocket coinsurance maximums	<p>BCBSAZ calculates member coinsurance payments and accruals toward deductibles and the out-of-pocket coinsurance maximums, based on the BCBSAZ allowed amount and based on a plan year. We do not use a provider's billed charges. In and out-of-network deductibles and maximums accumulate separately.</p> <p>Only the member's coinsurance payment counts towards the out-of-pocket coinsurance maximums. Many cost share payments do not count toward the out-of-pocket coinsurance maximum, including items indicated by "X" on the following list:</p> <table><tr><td>X deductibles</td><td>X copays</td></tr><tr><td>X precertification charges</td><td>X certain other charges specified in the benefit book</td></tr><tr><td>X amounts paid for noncontracted providers' balance bills</td><td>X amounts paid for noncovered services</td></tr><tr><td>X access fees</td><td></td></tr></table> <p>A member must continue to pay all the cost share amounts indicated above (other than deductible) even after meeting the maximum.</p>		X deductibles	X copays	X precertification charges	X certain other charges specified in the benefit book	X amounts paid for noncontracted providers' balance bills	X amounts paid for noncovered services	X access fees	
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X precertification charges	X certain other charges specified in the benefit book									
X amounts paid for noncontracted providers' balance bills	X amounts paid for noncovered services									
X access fees										
Physician Office Services Primary Care Physicians (PCP) include Family Practice, General Practice, Internal Medicine and Pediatrics. All other physicians are specialists.	<p>PCP: \$15 copay Specialist: \$25 copay</p> <p>Copay applies per member, per provider, per day for most covered services provided in a physician's office.</p> <p>90%/10% for other covered physician services, after meeting deductible. Deductible and coinsurance always apply to services rendered by radiologists, pathologists and physical, occupational and speech therapy services.</p>	70%/30% after meeting deductible.								
Preventive Services	<p>Plan pays 100% of allowed amount for covered preventive services; copays, deductible and coinsurance waived.</p> <p>Preventive services are those services performed for screening purposes when the member does not have active signs or symptoms of a condition. Preventive services do not include diagnostic tests performed because the member has a condition or an active symptom of a condition. The combination of the diagnosis and procedure codes submitted by the provider determines whether a service is preventive.</p>	<p>Most preventive services are not covered except mammography.</p> <p>Mammography: 70%/30%, deductible waived.</p>								
Urgent Care	\$35 copay per member, per provider, per day at facilities specifically contracted for urgent care.	70%/30% after meeting deductible.								
Laboratory Services	<p>In a physician's office, Plan pays 100%; physician office visit copay waived, if the only services a member receives during the visit are laboratory services.</p> <p>At contracted, freestanding, independent clinical labs, Plan pays 100%, deductible and coinsurance waived.</p> <p>At all other facilities, 90%/10% after meeting deductible.</p>	70%/30% after meeting deductible.								
Other Professional Services	<p>90%/10% after meeting deductible.</p> <p>Other professional services include diagnostic, surgical and anesthesia services rendered outside the physician's office.</p>	70%/30% after meeting deductible.								
Outpatient Facility Services	90%/10% after meeting deductible.	70%/30% after meeting deductible.								
Radiology Facility Services	<p>In a physician's office, applicable office visit copay applies.</p> <p>At all other facilities, 90%/10% after meeting deductible.</p>	70%/30% after meeting deductible.								
Inpatient – Hospital	90%/10% after meeting deductible.	70%/30% after meeting deductible.								

Emergency	\$75 access fee per member, per facility, per day; then 90%/10%, after meeting deductible; emergency room access fee is waived if member is admitted to the hospital.														
Ambulance	90%/10%, deductible waived.														
Prescription Medications at Retail and Mail Order Pharmacy	<table><tr><td><u>Copay Levels</u></td><td><u>Retail Pharmacy</u></td><td><u>Mail Order</u></td></tr><tr><td>Level One</td><td>\$ 7</td><td>\$14</td></tr><tr><td>Level Two</td><td>\$20</td><td>\$40</td></tr><tr><td>Level Three</td><td>\$40</td><td>\$80</td></tr></table> <p>Retail pharmacy copay: for up to a 30-day supply of a medication. Mail order pharmacy copay: for up to a 90-day supply of a medication.</p>	<u>Copay Levels</u>	<u>Retail Pharmacy</u>	<u>Mail Order</u>	Level One	\$ 7	\$14	Level Two	\$20	\$40	Level Three	\$40	\$80	<p>Retail Pharmacy: When a member fills a prescription at an out-of-network retail pharmacy, member pays applicable prescription medication copay plus the balance bill (difference between a pharmacy's price and the allowed amount).</p> <p>Mail Order: Not covered.</p>	
<u>Copay Levels</u>	<u>Retail Pharmacy</u>	<u>Mail Order</u>													
Level One	\$ 7	\$14													
Level Two	\$20	\$40													
Level Three	\$40	\$80													
Maternity	<p>Physician: One physician office visit copay covers physician's global delivery fee and other physician office visits for maternity services. For covered maternity services other than physician's global delivery fee, 90%/10% after meeting deductible.</p> <p>Hospital: 90%/10% after meeting deductible.</p>		Physician and Hospital: 70%/30% after meeting deductible.												
Chiropractic	\$25 copay per member, per provider, per day for most covered services 90%/10% for other covered services, after meeting deductible.		70%/30% after meeting deductible.												
Physical, Occupational & Speech Therapy	90%/10% after meeting deductible.		70%/30% after meeting deductible.												
Routine Vision Exams	\$15 copay for one routine vision exam per member, per plan year per member, per provider, per day. Cost share is waived for routine vision exams for members under age 5.		70%/30% after meeting deductible. Benefits limited to one exam per member, per plan year.												
Behavioral/Mental Health Member may choose in-network or out-of-network providers or the behavioral services administrator (BSA). BSA services are available only in Arizona.	<p>Inpatient: 90%/10% after meeting deductible.</p> <p>Outpatient: Non-BSA and BSA: Cost sharing waived.</p>		70%/30% after meeting deductible.												
Inpatient Extended Active Rehabilitation	90%/10% after meeting deductible, for up to 60 days. After 60 days, 50%/50%, up to an additional 60 days for the remainder of the plan year, which will not count toward out-of-pocket coinsurance maximum. Limited to 120 days per member, per plan year, combined in and out of network.		70%/30% after meeting deductible, for up to 60 days. After 60 days, 50%/50%, up to an additional 60 days for the remainder of the plan year, which will not count toward out-of-pocket coinsurance maximum.												
Skilled Nursing Facility	90%/10% after meeting deductible, for up to 90 days. After 90 days, 50%/50%, up to an additional 90 days for the remainder of the plan year, which will not count toward out-of-pocket coinsurance maximum. Limited to 180 days per member, per plan year, combined in and out of network.		70%/30% after meeting deductible, for up to 90 days. After 90 days, 50%/50%, up to an additional 90 days for the remainder of the plan year, which will not count toward out-of-pocket coinsurance maximum.												
Home Health and Infusion	90%/10% after meeting deductible.		70%/30% after meeting deductible.												
Specialty Self-Injectable Medications Through Specialty Pharmacy For certain specified self-injectable prescription biologic medications. Specialty self-injectable medications are not covered under the retail and mail order pharmacy benefit.	<u>Contracted Specialty Pharmacy</u> Level A: \$30 copay Level B: \$60 copay Level C: \$90 copay Level D: \$120 copay Please refer to azblue.com for a listing of specialty self-injectable medications and contracted specialty pharmacies or call BCBSAZ. Specialty self-injectable medications may also be available under the home health benefit, subject to deductible and coinsurance.		Not covered.												
Bariatric Surgery (Inpatient and Outpatient)	90%/10% after meeting deductible.		70%/30%, after meeting deductible.												

IMPORTANT INFORMATION

Allowed Amount: All claims are processed using the BCBSAZ "Allowed Amount." BCBSAZ reimbursement, member cost share payments, and accumulations toward deductible and out of pocket limits are calculated on the BCBSAZ Allowed Amount and based on a calendar year. The allowed amount is the total amount of reimbursement allocated to a covered service and includes both the BCBSAZ payment and the member cost share payment. It does not include any balance bill. The allowed amount is based on BCBSAZ or other fee schedules. It is not tied to and does not necessarily reflect a provider's regular billed charges.

Balance Bill: This is the difference between the BCBSAZ allowed amount and a noncontracted provider's billed charge. Except for emergency services, you are responsible for the balance bill.

Providers, Claims, and Out of Pocket Costs: This plan allows members to go to in and out-of-network providers. Network providers are independent contractors exercising independent medical judgment and are not employees, agents or representatives of BCBSAZ. BCBSAZ has no

control over any diagnosis, treatment or service rendered by any provider. In-network providers will file members' claims and generally cannot charge more than the allowed amount for covered services. Members have lower out-of-pocket costs for covered services when they use in-network providers. Noncontracted providers can charge members full billed charges, which will include the difference between the BCBSAZ allowed amount and the provider's regular billed charges ("the balance bill"). Members are responsible for paying up to a noncontracted provider's billed charges for covered services, even though BCBSAZ will reimburse members' claims based on the allowed amount, less any deduction for the member's cost share portion. Any amounts paid for balance bills do not count toward any deductible, coinsurance or out-of-pocket coinsurance maximum.

EMERGENCY SERVICES: For emergency services, you will pay your in-network cost share, even if services received are from out-of-network providers. If you receive emergency services from a noncontracted provider, you will also be responsible for the balance bill, which may be substantial.

Precertification: Some services and medications require precertification. Except for emergencies, urgent care, and maternity admissions, precertification is always required for inpatient admissions (acute care, behavioral health, long term acute care, extended active rehabilitation, and skilled nursing facilities) and specialty injectable medications. Precertification may be required for other covered services and medications. The member is responsible for making sure his or her physician obtains precertification approval if it is required. If precertification is not obtained, the member's benefits may be denied or the member may be subject to a precertification charge. Information on precertification requirements, including a list of medications that require precertification, and the process for obtaining precertification is available on the BCBSAZ Web site at azblue.com or by calling BCBSAZ at (602) 864-4273 or (800) 232-2345, ext. 4273.

Medications and Prescriptions

- When the price BCBSAZ pays an in-network pharmacy for a medication is less than the member's cost-sharing, some pharmacies will charge the member the BCBSAZ price. However, most pharmacies will charge the member the retail price (if also less than the cost-sharing), rather than the BCBSAZ price. The member will not be required to pay more than the applicable cost-sharing for covered medications at an in-network pharmacy.
- BCBSAZ applies limitations to certain prescription medications obtained through the retail and mail order pharmacy benefit. A list of these medications and limitations is available online at azblue.com or by calling BCBSAZ. These limitations include, but are not limited to, quantity, age, gender and refill limitations. BCBSAZ prescription medication limitations are subject to change at any time without prior notice.

Preexisting Conditions

AN 11 MONTH WAITING PERIOD FOR PRE-EXISTING CONDITIONS MAY APPLY FOR MEMBERS AGE 19 AND OLDER. A pre-existing condition is defined as a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) month period immediately preceding the member's enrollment date. A condition exists when the member had signs or symptoms, whether or not a specific injury, illness or disease is diagnosed. For purposes of determining a pre-existing condition and pre-existing condition waiting periods, enrollment date means the member's effective date of coverage under this benefit plan or the first day of the group's eligibility waiting period, whichever is earliest. Pregnancy is not considered a pre-existing condition. Credit will be given for periods of prior creditable coverage as long as there was no period of sixty-three (63) days or more (excluding the employer group's eligibility waiting period) during which a member was not covered under any creditable coverage. Creditable coverage includes the following: coverage provided under a group health plan (insured or self-insured), an individual insurance policy, Medicare, Medicaid, a federal or state public health plan, a health risk benefits pool, TRICARE, the Peace Corps, a Bonafide Association, Indian Health Services, the Federal Employee Health Benefits Plan or the State Children's Health Insurance Plan. Members have the right to demonstrate to BCBSAZ that they have had prior creditable coverage by providing a Certificate of Creditable Health Coverage or other documentation of such coverage. BCBSAZ can calculate creditable coverage prior to member's effective date upon request. Please call our Membership Services Department at (602) 864-4456 or (800) 232-2345, Ext. 4456 for additional information.

IMPORTANT WARNING

THIS IS ONLY A BRIEF SUMMARY OF THIS BENEFIT PLAN. MORE DETAILED INFORMATION REGARDING BENEFITS, LIMITATIONS AND EXCLUSIONS IS IN THE BENEFIT PLAN BOOKLET AND IS AVAILABLE PRIOR TO ENROLLMENT, ON REQUEST. IF THE TERMS OF THIS SUMMARY DIFFER FROM THE TERMS OF THE BENEFIT PLAN BOOKLET, THE TERMS OF THE BOOKLET CONTROL AND APPLY.

EXCLUSIONS & LIMITATIONS

The following is a partial list of conditions and services that are limited or excluded. Expenses for services that exceed benefit limitations are not covered. Detailed information about benefits, limitations and exclusions is in the benefit book and is available prior to enrollment, upon request.

- Abortions, except as stated in the benefit plan
- Activity therapy
- Acupuncture
- Alternative medicine, non-traditional and alternative medical therapies; interventions; services and procedures not commonly accepted as part of allopathic or osteopathic curriculum and practices; naturopathic and homeopathic medicine; diet therapies; aromatherapy
- Benefit-specific exclusions and limitations listed in the benefit book under particular benefits
- Biofeedback and hypnotherapy, except as stated in the benefit plan
- Body art, piercing, tattooing and any related complications
- Certain types of inpatient and outpatient facility charges by: group homes, wilderness programs, boarding schools, halfway houses, assisted living centers or shelters. Inpatient and outpatient facility charges for residential treatment facilities except for certain, very limited situations based upon BCBSAZ medical necessity criteria.
- Charges associated with the preparation, copying or production of health records
- Cognitive and vocational therapy
- Complications of noncovered benefits

- Computer speech training and therapy programs and devices
- Cosmetic services and any related complications – surgery and any related complications, procedures, treatment, office visits, consultations and other services for cosmetic purposes. This exclusion does not apply to breast reconstruction following a medically necessary mastectomy.
- Counseling and behavioral modification services, except as stated in the benefit plan
- Court-ordered services, except as stated in the benefit plan
- Custodial care
- Dental, except as stated in the benefit plan
- Dietary and nutritional supplements, except as stated in the benefit plan
- Expenses for services that exceed benefit limitations
- Experimental or investigational services
- Fees for concierge medicine services
- Fees other than for medically appropriate in-person, direct member services, except as stated in the benefit plan
- Fertility and infertility services, including reproductive and genetic services
- Flat feet
- Foot care, except as stated in the benefit plan
- Free services
- Genetic and chromosomal testing and screening
- Government services provided at no charge to the member through a governmental program or facility
- Growth Hormone except as specified in the BCBSAZ Medical Coverage Guidelines, and growth hormone to treat Idiopathic Short Stature (ISS)
- Hearing services and devices, except as stated in the benefit plan
- Lifestyle education and management services, except as stated in the benefit plan
- Lodging and meals, except as stated in the benefit plan
- Maintenance Services – services rendered after a member has met functional goals; services rendered when no objectively measurable improvement is reasonably anticipated, services to prevent regression to a lower level of function, services to prevent future injury and services to improve or maintain posture
- Manipulations of the spine under anesthesia
- Massage therapy, except in limited circumstances as described in the BCBSAZ Medical Coverage Guidelines
- Medical equipment, supplies and medications sold on or through unregulated distribution channels as determined by BCBSAZ
- Medical marijuana and any costs or fees associated with obtaining medical marijuana.
- Medications dispensed in certain settings – prescription medications given to the member by any person or entity that is not a licensed pharmacy, home health agency, specialty pharmacy or hospital emergency room
- Medications – Medications which are:
 - Not FDA approved
 - Not required by the FDA to be obtained with a prescription
 - Not used in accordance with the BCBSAZ Medical Coverage Guidelines
 - Used to treat a condition not covered by BCBSAZ
 - Off-label, unlabeled and orphan medications, except as stated in the benefit plan
- Neurofeedback
- Non-medically necessary services, as determined by BCBSAZ. BCBSAZ may not be able to determine medical necessity until after services are rendered
- Over-the-counter items, except as stated in the benefit plan
- Personal comfort items
- Reversal of sterilization
- Screening tests, except as stated in the benefit plan
- Services for Idiopathic Environmental Intolerance
- Services for sexual dysfunction, regardless of the cause and all medications for the treatment of sexual dysfunction
- Services for weight loss and gain, except as stated in the benefit plan
- Services from a family member – services that are provided by an eligible provider who is part of the member's immediate family as defined in the benefit plan. When a provider is also the covered person, services rendered by that provider for him/herself are excluded from coverage.
- Services from ineligible providers
- Services paid for by other organizations
- Services provided after the member's coverage termination date, except as stated in the benefit plan
- Services provided by a proficient substitute for a professional caregiver
- Services provided prior to effective date
- Services related to or associated with noncovered services
- Services without a prescription, when a prescription is required
- Smoking cessation programs, medications, aids and devices except as stated in the benefit plan
- Spinal decompression or vertebral axial decompression therapy
- Strength training, except as stated in the benefit plan
- Telephonic and electronic consultations, except as stated in the benefit plan
- Therapy services, except as stated in the benefit plan
- Training and education, except as stated in the benefit plan
- Transplants and related services not precertified by BCBSAZ
- Transportation services and travel expenses, except as stated in the benefit plan
- Transsexual treatment, surgery, medications and related services

- Vision therapy; all types of refractive keratoplasties; any other procedures, treatments and devices for refractive correction; eyeglasses and contact lenses; vision examinations for fitting of eyeglasses and contact lenses, except as stated in the benefit plan
- Vitamins, except as stated in the benefit plan
- Workers' Compensation – illnesses or injuries covered by Workers' Compensation, unless the member is exempt from such coverage or has made a statutory opt-out election

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BENEFIT PLAN CHANGES
City of Surprise
Group No. 23348/Effective Date: 07/01/2012

PPO

Effective upon renewal on and after July 1, 2012, the following changes will apply to this benefit plan:

EMERGENCY SERVICES

Currently, reimbursement for emergency services provided by a noncontracted provider is based on the provider's billed charges. Reimbursement for emergency services provided by a noncontracted provider will now be based on whichever of the following amounts is highest:

- The median in-network provider negotiated rate for the emergency service furnished,
- The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services, and
- The amount that would be paid by Medicare Part A or B.

This change in reimbursement is likely to result in a balance bill (the difference between the reimbursed amount and the billed charge.)

Currently, with reimbursement for out-of-network emergency services based on billed charges, members do not face a balance bill from a noncontracted provider. Member cost share responsibility for out-of-network emergency services from a noncontracted provider, will now include any balance bill, in addition to any applicable copay, deductible, coinsurance, or access fee.

PHYSICAL AND OCCUPATIONAL THERAPY

Currently, this benefit plan covers certain types of group physical and occupational therapy. This benefit plan will no longer cover any group physical or occupational therapy, regardless of diagnosis.

Federal and state statutes and regulations may require additional changes to this benefit plan. BCBSAZ will advise employer groups and members of any additional changes to this benefit plan required by applicable federal and state law.